INSTRUCTIONS FOR MAINECARE HOME HEALTH REFERRAL ATTACHMENT

(Age 21 and older)

Member: Fill in the member's name as it appears on the referral form.

MaineCare #: Fill in the member's MaineCare number.

The referral attachment must be completed for referrals made to Goold Health Systems for MaineCare Home Health assessments. This attachment must:

- Include a certified plan of care or physician orders signed by the member's physician. Check one of the following:

  ☐ The HCFA 485 plan of care signed by the member's physician is attached. This must be included when requesting an assessment for prior authorization of MaineCare Home Health.
  OR

  ☐ Physician orders are attached. These will be accepted in lieu of the HCFA 485 when the consumer is in the hospital, awaiting discharge at time of assessment.

AND

- Provide a statement to explain why the services are not available and safely accessible to the member on an outpatient basis. Outpatient services must be medically contraindicated, or not possible for the member to access. **A reason must be specified on the attachment**. If a reason is not provided the referral will be considered incomplete and result in a delay in determining medical eligibility for continuation of care. This may result in a gap in payment.

  ☐ Medically contraindicated with likelihood of a bad result

  Specify reason: _____

AND

- The member's condition requires skilled nursing care on a "part-time" or "intermittent" basis, or physical, occupational, or speech therapy as defined in Section 40.02-3 (E).

Prior Authorization Required: Check the category of service that you are requesting Goold Health Systems to prior authorize for this member.

- If you are requesting prior authorization for assessment/management, you must indicate the Start of Care Date in space provided:

  Assessment/Management: ____/____/____;

Person completing this form: Sign this attachment in the space provided.

Date: Enter the date that this attachment was completed in the space provided.

Provider Name: Include your provider agency name.

Fax the referral attachment with the referral form and plan of care to Goold Health Systems at **1-800-368-0965**.